

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

11360

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

### 1. PLACE OF DEATH:

County Talbot  
City or town Canton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death 5 hrs. 45 min.  
Hospital, institution, or street address where death occurred:  
Memorial Hospital  
How long in hospital or institution? 5 hrs. 45 min.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Talbot  
City or town Canton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Eva Belle Austin

### 3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mr. Walter F. Austin

7. Birth date of deceased (mo., day, yr.) Oct 9, 1875 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 70 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace King Nevada  
(Town, county, and state)

10. Usual occupation H W

11. Industry or business \_\_\_\_\_

FATHER 12. Name Harvey Thompson

13. Birthplace Oregon Territory

MOTHER 14. Maiden name Beth Adamson

15. Birthplace Sunder Scotland

16. Informant Mr. Walter Austin

Address 217 Adkins Ave, Canton, Md.

17. Cremation Date thereof Nov. 10, 1945  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Washington, D.C.

18. Funeral director J. Lewis Clark News.

Address Canton, Md.

19. 11/9 19 45 N. R. Merino  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 19 45 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 45 to 9 November 19 45

and that I last saw him/her alive on 9 November 19 45

Immediate cause of death Coronary Thrombosis

Other conditions Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cholelithiasis

Quintessential 2 colon  
(Include pregnancy within 9 months of death)

Major findings of operations \_\_\_\_\_

Antopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M. V. Palmer MD  
M. D. or other \_\_\_\_\_

Address 5000 Maryland Date signed 11/9/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 20 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (232)

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Queen Anne's  
 City or town Rural Eastern, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Talbot.  
 City or town Rural Eastern, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Olara Dean Bailey

## 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed.  
 6.(b) Name of husband or wife John W. Bailey.  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) Oct. 9, 1866  
 8. AGE: Years 79 Months - Days 28 If less than one day  
 ..... hrs. .... min.

9. Birthplace Wagons Mills, N. Y.  
(Town, county, and state)10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Irish Safford  
 13. Birthplace

MOTHER 14. Maiden name Ann Sket.  
 15. Birthplace England.

16. Informant Mrs. Anna R. Bailey  
 Address Eastern, Md. R.D.

17. Burial Date thereof Nov. 9, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill  
 Location Eastern, Md.

18. Funeral director Wm. Clark  
 Address Eastern, Md.

19. 11/8 19 45 N. H. Neerins  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 19 45, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Nov. 7 19 40 to Nov. 7 19 45  
 and that I last saw him alive on Nov. 7 19 45

Immediate cause of death Acute myocardial infarction  
 DURATION

Due to arteriosclerosis

Due to

Other conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Dylan Balm M.D.  
Eastern M. D. or other  
 Address Date signed 11-8-45

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NOV 14 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 582

## CERTIFICATE OF DEATH

De Lewis 1362

★ Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Belleme  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County TalbotCity or town Belleme  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Isaac Ballard

## 3. (b) Social Security Number

217-03-7737

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary Fichter

7. Birth date of deceased (mo., day, yr.)

March - 1880B.(c) Date of death Nov 5 1945 years

8. AGE:

Years

Months

Days

If less than one day

657

hrs.

min.

9. Birthplace

Crisfield, Md.  
(Town, county, and state)

10. Usual occupation

Oyster Shucker

11. Industry or business

MOTHER FATHER

12. Name

Isaac Collins

13. Birthplace

Crisfield

14. Maiden name

Mary Ballard

15. Birthplace

Crisfield, Md.

16. Informant

Mary Ballard

Address

Belleme, Md.

17.

Burial  
(Burial, cremation, or removal, Which?)

Date thereof

Nov 8-45  
(month) (day) (year)

Cemetery or crematory

St. Luke Cemetery

Location

Belleme, Md.

18. Funeral director

John D. Williams

Address

Easton, Md.

19.

11/6  
(Date rec'd by registrar)

19

45N.H. Neuma

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov 5 19 45, at 4:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1, 1938

19

to Nov 5, 1945

19

and that I last saw him alive on Nov 4, 1945 19

Immediate cause of death

Neurosyphilis

DURATION

7 yrs

Due to

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. Shewell

M. D. or other

Address St. Michaels, Md.Date signed 11-7-45

RECEIVED  
NOV 10 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Diat. No. 11363 290

## 1. PLACE OF DEATH:

County Eastern  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 years  
 Hospital, institution, or street address where death occurred:  
307 North St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 307 North St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

JOSEPH EDWARD BILDSTEIN

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 B. (b) Name of husband or wife Mary M. Bildstein  
 7. Birth date of deceased (mo., day, yr.) May 13, 1867 6. (c) If alive, give age ..... years  
 8. AGE: Years 78 Months 5 Days 22 If less than one day ..... hrs. .... min.

9. Birthplace Albion, Lorraine  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business Farming  
 12. Name Bildstein  
 13. Birthplace Albion, Lorraine  
 14. Maiden name Madeline Huber  
 15. Birthplace Albion, Lorraine  
 16. Informant Mrs. James Emerson (Daughter)  
 Address 307 North St. - Easton Md.  
 17. Burial Date thereof Nov. 8, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Spring Hill  
 Location Easton, Md.  
 18. Funeral director W. E. Clark  
 Address Easton, Md.  
 19. 11/6 19 45 N. H. Myers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 19 45 at 6:30 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....  
 and that I last saw him ..... alive on ..... 19 .....  
 Immediate cause of death .....  
Coronary occlusion  
 Due to .....  
 Due to .....  
 Other conditions Renal arteriosclerosis  
 (Include pregnancy within 8 months of death)

## DURATION

Infant

Major findings of operations ..... Date of op. ....  
 Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work?  
 23. SIGNATURE Louis D. Wright, M.D. Dep. Medical  
Easton, Md. M. D. or other  
 Address ..... Date signed 11-5-45



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NOV 20 1945

BUREAU V.R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195-2

## CERTIFICATE OF DEATH

11364

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 Years  
 Hospital, institution, or street address where death occurred:  
108 Locust  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 108 Locust St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

DELLA VIRGINIA BROOKS

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Charles Brooks  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 24, 1893  
 8. AGE: Years 52 Months 4 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

B. Birthplace Talbot Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Domestic  
 11. Industry or business St. Home  
 12. Name John Smith  
 13. Birthplace Maryland  
 14. Maiden name Margaret D. Rimmer  
 15. Birthplace Maryland

18. Informant Rddie Roberts  
 Address Concorda Md.  
 17. Burial Date thereof Nov. 26, 1945  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Richards  
 Location Easton Md.

18. Funeral director R. E. Clark  
 Address Easton, Md.  
 19. 11/26/45 19. N. H. Rimmer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1945, at 2:12 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20, 1945 to Nov 21, 1945  
 and that I last saw him alive on Nov 20, 1945

Immediate cause of death Acute Bright's disease DURATION 2 days  
 Due to Emphysema  
 Due to \_\_\_\_\_  
 Other conditions Chemia Acute  
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. ✓  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of ✓  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of Injury \_\_\_\_\_ Injured at work? ✓  
 23. SIGNATURE S. B. Shewers M. D. or other St. Michaels, Md.  
 Address \_\_\_\_\_ Date signed 1023.45

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NOV 27 1945

BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 882

## CERTIFICATE OF DEATH

Reg. Dist. No. 392

### 1. PLACE OF DEATH:

County Subt  
City or town Offord  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 9 mo  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Subt  
City or town Offord  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Gertrude Marley Carpenter

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Thomas M. Carpenter  
6. (c) If alive, give age 57 years  
7. Birth date of deceased (mo., day, yr.) July 8, 1900  
8. AGE: Years 45 Months 4 Days 13 If less than one day  
hrs. min.

9. Birthplace Haverhill N. Y.  
(Town, county, and state)

10. Usual occupation Laundry

11. Industry or business

12. Name George W. Marley

13. Birthplace Pa.

14. Maiden name Gertrude Peters

15. Birthplace N. Y.

16. Informant Thomas M. Carpenter

Address Offord, Md.

17. Buried Date thereof Nov 25, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Offord, Md.

Location Offord, Md.

18. Funeral director Bliss Club

Address Offord, Md.

19. Nov. 23 1945  
(Date rec'd by registrar)

Joseph A. Conner  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1945 at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1945 to Nov 21 1945 and that I last saw h. or alive on Nov 20 1945

Immediate cause of death

Cerebral hemorrhage Apoplexy DURATION 40 min

Due to Arteriosclerosis Cerebr. 2

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph A. Conner M. D. or other

Address Offord, Md. Date signed 11/23/45

MARGIN RESERVED FOR BINDING

9-45

VS 416

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11365

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NOV 26 1945  
BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 292

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

19. 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

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NOV 27 1945

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Calvert  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Years  
 Hospital, institution, or street address where death occurred:  
40 Locust St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 40 Locust St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ELIZA COXON

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored Widow

6. (b) Name of husband or wife

Henry Coxon

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years

1876  
 8. AGE: Years 69 Months - Days - If less than one day hrs. min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?) Date thereof

Cemetery or cremation

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 1, 1945 to Nov. 14, 1945

and that I last saw her alive on Nov. 13, 1945

Immediate cause of death

Acute Uremia

Essential Hypertension

Due to

Arteriosclerotic Nephritis

Due to

Other conditions Generalized Arteriosclerosis

sis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

st. Michaels, Md.

Address

Date signed 11/16/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
NOV 20 1945  
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 338

11368

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: Palhat  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? one year five months  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State ma County Palhat  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 223 East  
 (If rural, give LOCATION) no  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Greenbury Gibson

3. (b) Social Security Number

4. Sex male 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced widower

B. (b) Name of husband or wife male Gibson

7. Birth date of deceased (mo., day, yr.) about 1883 6. (c) If alive, give age don't know years

8. AGE: Years about 62 Months - Days - It less than one day hrs. min.

9. Birthplace Coffeyville  
 (Town, county, and state)

10. Usual occupation laborer

11. Industry or business same as above

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs. Ida Brooks

Address Easton md

17. Burial Date thereof Nov 21-1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Coffeyville

Location near Easton md

18. Funeral director James P. Stewart

Address Salisbury md

19. 11/18 19 45 W. H. Neerius  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 19 45 at 11:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 19 45 to Nov. 17 19 45

and that I last saw him alive on Nov. 17 19 45

Immediate cause of death Influenza

DURATION 6-7 days

Due to Exposure & death

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE Howard T. Pratt, M.D.

Address Easton, Md. Date signed 11/18/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NOV 23 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

11369

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital, Easton, Maryland

How long in hospital or institution?

3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Federalburg, P.D.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Mulliger

## 3. (b) Social Security Number

no

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Marie Mulliger

7. Birth date of

deceased (mo., day, yr.)

Oct. 23, 1863

8. AGE:

82

Years

Months

Days

If less than one day

29

hrs.

min.

9. Birthplace

Berne, Switzerland  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Retired

12. Name

Johannes Mulliger

13. Birthplace

Switzerland

14. Maiden name

Van Buren

15. Birthplace

18. Informant

Mrs. Robert Ischore

Address

Federalburg, Md.

17.

(Burial, cremation, or removal, Which?)

Date of event

Nov. 25, 1945  
(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Federalburg, Maryland

18. Funeral director

J. J. Thompson & Son

Address

Federalburg, Maryland

19.

(Date rec'd by registrar)

19

45M. H. Neeriv

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH November 22, 1945 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 19, 1945 to November 22, 1945and that I last saw him alive on November 22, 1945

Immediate cause of death

Coronary thrombosis  
Chronic myocarditis  
Broncho pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Lynn Baker, M.D.

M. D. or other

Address

Easton

Date signed

11-28-45

RECEIVED

DEC 4 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

## CERTIFICATE OF DEATH

11370

Reg. Dist. No. 27

## I. PLACE OF DEATH:

County..... Talbot Co.  
 City or town..... Grapple (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 4 years  
 Hospital, institution, or street address where death occurred:  
Rural (Bruceville)  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Talbot  
 City or town..... Grapple (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Rural (Bruceville)  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

ROBERT THOMAS KNOX

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Mary Eliz. Knox  
 6. (c) If alive, give age..... 61 years  
 7. Birth date of deceased (mo., day, yr.)..... Sept. 6, 1880  
 8. AGE: Years..... 65 Months..... 2 Days..... 3 If less than one day..... hrs. .... min.

9. Birthplace..... Talbot County, Md.  
 (Town, county, and state)  
 10. Usual occupation..... Retired  
 11. Industry or business..... Farmer  
 12. Name..... Robert T. Knox  
 13. Birthplace..... Maryland  
 14. Maiden name..... Sarah Jane Blackston  
 15. Birthplace..... Maryland

16. Informant..... Mrs. Robert T. Knox  
 Address..... Grapple, Md.  
 17. Burial (Burial, cremation, or removal? Which?) Date thereof..... Nov. 12, 1945  
 (month) (day) (year)  
 Cemetery or crematory..... Spring Hill  
 Location..... Easton, Md.  
 18. Funeral director..... R. Betty Clark  
 Address..... Easton, Md.

19. Nov. 11 1945 Registrar..... Jouglas Con  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 9 1945, at 12 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 1943 to..... Nov 9 1945  
 and that I last saw him alive on..... Nov 9 1945

Immediate cause of death..... Cerebral Sclerosis  
 Due to..... Arterio-sclerosis  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury..... Injured at work? .....

23. SIGNATURE..... Jouglas Con M. D. or other.....  
 Address..... Grapple, Md. Date signed..... 11/11/45

RECEIVED  
NOV 12 1945  
BUREAU V \*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

## CERTIFICATE OF DEATH

Reg. Dist. No.

11371  
294

## 1. PLACE OF DEATH:

County TalbotCity or town Tilghman  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long to hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County TalbotCity or town Tilghman  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Olin A. Iniatu

## 3. (b) Social Security Number

218-07-17834. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife W. Reid Iniatu7. Birth date of deceased (mo., day, yr.) Feb. 19, 19136. (c) If alive, give age 34 years8. AGE: Years 32 Months 8 Days 26  
If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Tilghman md  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name James L. Murphy13. Birthplace Talbot Co. md14. Maiden name Bertine Garvin15. Birthplace Tilghman md18. Informant W. Reid IniatuAddress Tilghman, md11. Burial Nov. 27, 1945

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory CemeteryLocation Tilghman md18. Funeral director Thronan & HarrisonAddress St. Michaels md19. Nov 17 19 45 G. J. Johnson

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 19 45 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him at home on Nov 14 19 45Immediate cause of death Chronic valvular DURATIONHeart disease 15 years(Long & complicated) 2 weeksDue to retrograde cough

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work?

23. SIGNATURE G. J. JohnsonM. D. or other Nov 14 1945Address Tilghman md Date signed \_\_\_\_\_

RECEIVED TO THE SECRETARY OF THE ARMY

CERTIFICATE OF DEATH

RECEIVED  
DEC 5 1945  
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(31-2)

11372

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:  
 County Talbot  
 City or town St. Michaels  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town St. Michaels  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
Martha R. Nichols

3. (b) Social Security Number  
None

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Grason Nichols  
 7. Birth date of deceased (mo., day, yr.) Sept. 4 1898 6. (c) If alive, give age 52 years

8. AGE: Years 47 Months 2 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ m./n.

9. Birthplace Claiborne, Talbot Co., Maryland  
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name John R. Roberts  
 13. Birthplace Talbot Co. Md.

14. Maiden name Josephine Green  
 15. Birthplace Bozman, Talbot Co., Maryland

16. Informant Madge Waters  
 Address St. Michaels, Maryland

17. Burial Date thereof Nov. 25 '45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery  
 Location St. Michaels, Maryland

18. Funeral director J. Norman Marshall  
 Address St. Michaels, Maryland

19. Nov 24 19 45 John H. Waters  
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
 20. DATE OF DEATH November 22, 1945 19\_\_\_\_ at 7:45 P

21. I CERTIFY that death occurred on the date above stated; that it attended deceased from Sept. 30, 1945 19\_\_\_\_ to Nov. 22, 1945 19\_\_\_\_  
 and that I last saw him alive on Nov. 22, 1945 19\_\_\_\_

Immediate cause of death  
Acute Uremia  
Essential Hypertension  
Arteriosclerotic Nephritis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

DURATION

9 mos.

Major findings of operations None Date of op. None

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. P. Brewster M. D. or other  
 Address St. Michaels, Md Date signed 11.24.45

RECEIVED

DEC 5 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age & year of birth of deceased is shown on  
 FILM No. I 00 JAN 8 1946

Doctor's statement attached permanently.

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

11373

1. PLACE OF DEATH:

County Calbot

City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Graham's Alley

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calbot

City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Graham's Alley  
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

JAMES A. OCKEMAY

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Flourice Ockemay

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Dec. 25, 1886

1886 or 1887

8. AGE:

Years

Months

Days

If less than one day

57 or 58 76

10

23

hrs.

min.

9. Birthplace

Calbot Co. Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Ockemay

13. Birthplace

Md.

MOTHER

14. Maiden name

Mary Ellen Hopkins

15. Birthplace

Md.

16. Informant

Arthur James Ockemay (Son)

Address

Easton, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 25, 1945  
 (month) (day) (year)

Cemetery or crematory

Richards

Location

Easton, Md.

18. Funeral director

Address

Easton, Md.

19.

Nov 24 1945  
 (Date rec'd by registrar)

N. R. Peirson  
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 18

19

45 at 5:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 10, 1945 19 45 at Nov 18, 1945

and that I last saw him alive on Nov 17, 1945 19 45

Immediate cause of death

Lobar pneumonia

DURATION

8 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. S. Shewers

M. D. or other

Address

W. S. Shewers  
 signed 11.21.45

RECEIVED  
NOV 27 1945  
BUREAU V.R.

PHILIP BROOKS LEWIS, M. D.  
ST. MICHAELS, MARYLAND  
January 4, 1946

JAN 7 1946

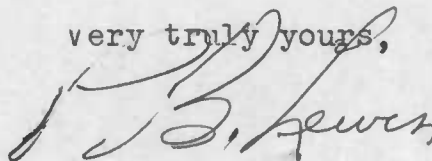
State Of Maryland Dep't Of Health  
Baltimore, Maryland.

Re: James Ockemay (deceased)

Dear Sirs,

May I advise that James Ockemay who died in Easton, Maryland, November 18, 1945 was apparently 57 or 58 years of age, despite the information given on the death certificate, which I believe not to be too authentic.

very truly yours,

A handwritten signature in dark ink, appearing to read "P. B. Lewis", written over the typed name "Philip Brooks Lewis". The signature is fluid and cursive.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

11374

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County WYCOMB: LLS. Talbot Co. Md.City or town Wye Mills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death 60 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County TalbotCity or town Wye Mills  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

PERRY ROLLISON

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

B. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Nov. 6, 1858

## 8. AGE:

Years

Months

Days

If less than one day

8717

hrs.

min.

## 9. Birthplace

Talbot County  
(Town, county, and state)

## 10. Usual occupation

Carpenter

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Perry Rollison

## 13. Birthplace

Talbot Co. Md.

## 14. Maiden name

Mary E. Sullivan

## 15. Birthplace

Talbot Co. Md.

## 16. Informant

Ruth Gruell

## Address

Wye Mills, Md.

## 17. Burial:

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

Nov. 26/45  
(month) (day) (year)

## Cemetery or crematory

Chesterfield, Centerville

## Location

Maryland

## 18. Funeral director

Carl W. Stafford

## Address

Centerville, Md.

## 19.

11/24 45  
(Date rec'd by registrar)R. D. Neeris

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1945 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 17 1945 to Nov 22 1945and that I last saw him alive on Nov 22 1945

## Immediate cause of death

## DURATION

Cerebral Hemorrhage

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

W. Henry Fisher

M. D. or other

## Address

Centerville Md.Date signed 11/26/45

RECEIVED

DEC 4 1945

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

## CERTIFICATE OF DEATH

★ Reg. Dist. No. *290*

### 1. PLACE OF DEATH:

County *Talbot*  
City or town *Easton*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *46 yrs*  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Md.* County *Talbot*  
City or town *Easton*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

*Emma Sherwood*

### 3. (b) Social Security Number

*None*

4. Sex *Female* 5. Color or race *Colored* 6. (a) Single, married, widowed, or divorced *Widow*

6. (b) Name of husband or wife *Perry Sherwood*  
*deceased*

7. Birth date of *about* 8. (c) If alive, give age *deceased*  
deceased (mo., day, yr.) *April 20, 1880*

8. AGE: Years *65* Months *6* Days *12* It less than one day *hrs.* min.

9. Birthplace *Toytown, Talbot Co. Md.*  
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *at home*

12. Name *Unknown*

13. Birthplace *Unknown*

14. Maiden name *Rachel Blake*

15. Birthplace *Toytown, Easton, Md.*

16. Informant *Mary Sherwood Douglass*

Address *Easton, Md.*

17. *Burial* Date thereof *Nov. 5 - 45*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Richards Cemetery*

Location *Easton, Md.*

18. Funeral director *J. D. Williams*

Address *Easton, Md.*  
19. *11/3* 19. *45* *N. H. Harris*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 1* 19. *45* at *9:20 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 24* 19. *45* to *Nov 1* 19. *45*

and that I last saw him alive on *Nov. 1* 19. *45*

Immediate cause of death *Septicemia*

Due to *Fracture of the*

*Procraster*

Due to *Fall out door*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *Sept 24/45*

Where did injury occur? *Easton Talbot Md.*  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *at home*

Means of injury *Fall* Injured at work? *no*

23. SIGNATURE *Hyman T. M.D.*  
Address *Easton, Md.* Date signed *11/3/45*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11375

WASHINGTON STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

NOV 10 1945

BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11376

290

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Talbot

City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital, Easton, Md.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1025 Plum Alley  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Clarence Simms

### 3. (b) Social Security Number

#### 4. Sex

M

#### 5. Color or race

Black

#### 6. (a) Single, married, widowed, or divorced

Single

#### 6. (b) Name of husband or wife

6. (c) If alive, give age years

#### 7. Birth date of deceased (mo., day, yr.)

Oct. 15, 1902

#### 8. AGE:

43

Years

Months

Days

If less than one day

hrs.

min.

#### 9. Birthplace

Calvert Co. Md.  
(To county, and state)

#### 10. Usual occupation

Laborer

#### 11. Industry or business

FATHER  
MOTHER

#### 12. Name

James Simms

#### 13. Birthplace

Md.

#### 14. Maiden name

Elija Bunday

#### 15. Birthplace

Md.

#### 16. Informant

Katie Moore

#### Address

1025 Plum Alley, Balto Md

#### 17.

Burial

Date thereof

11/17/45

(Burial, cremation, or removal, which?)

(month) (day) (year)

#### Cemetery or crematory

Balto Md

#### Location

Balto Md.

#### 18. Funeral director

#### Address

1084 Montgomery St, Baltimore

#### 19.

11/5

19

45

N. H. Nevins

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 19 45 at 2:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 12 19 45 to November 14 19 45

and that I last saw him alive on November 14 19 45

Immediate cause of death Obstetric hemorrhage

uterine

#### DURATION

6 days

Due to

adhesions, post partum

4 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

No operation

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John A. Noble

M. D. or other

Address

Easton Md

Date signed

11/23/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 29 1945  
BUREAU

*[Faint handwritten notes at the bottom of the page]*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 296

11377

## 1. PLACE OF DEATH:

County..... Talbot  
 City or town..... Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Life  
 Hospital, institution, or street address where death occurred:  
19 Glenwood Ave.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Talbot  
 City or town..... Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 19 Glenwood Ave.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

ALBERT EARL SOULSBY

## 3. (b) Social Security Number

213-01-8397

4. Sex..... Male 5. Color or race..... White 6. (a) Single married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Julia Virginia Camper

7. Birth date of deceased (mo., day, yr.)..... June 20, 1901 6. (c) If alive, give age..... 44 years

8. AGE: Years..... 44 Months..... 4 Days..... 11 If less than one day..... hrs. .... min.

9. Birthplace..... Easton, Maryland  
(Town, county, and state)10. Usual occupation..... Mechanic11. Industry or business..... Garage12. Name..... Charles Milton Taylor Soulsby13. Birthplace..... Maryland14. Maiden name..... Julia Elizabeth Tolt15. Birthplace..... Maryland16. Informant..... Mrs. Albert E. SoulsbyAddress..... Easton, Md.

17. Burial Date thereof..... Nov. 14, 1945  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Spring HillLocation..... Easton, Md.18. Funeral director..... R. E. ClarkAddress..... Easton, Md.

19. 11/10 19..... 1945  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 11-11 19..... 45 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 10-10 19..... 45Immediate cause of death..... Cerebral ThrombosisDue to..... Cerebral Thrombosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... J. Tyler Baker M.D.Address..... Easton M. D. or otherDate signed..... 11-12-45



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NOV 20 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B1-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot CountyCity or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

in an aneurysm, HospitalHow long in hospital or institution? 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Denton  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Walters T. Hawley

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Helen Hawley7. Birth date of deceased (mo., day, yr.) June 20, 18858. AGE: Years 60 Months 9 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace near Concord Md.  
(Town, county, and state)10. Usual occupation News Agent

## 11. Industry or business

12. Name Wm. T. T. Hawley13. Birthplace Md.14. Maiden name Mary D. Walters15. Birthplace Md.16. Informant Mrs. Helen T. HawleyAddress Denton Md.17. Burial Date thereof 11/13/45  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Eastern CemeteryLocation J. Denton, Md.18. Funeral director J. Vigil MortuaryAddress Denton, Md.19. 11/11 19 45 N.H. Myers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 19 45 at 1 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 October 19 45 to 10 November 19 45and that I last saw him alive on 10 November 19 45Immediate cause of death uræmia

## DURATION

1 monthDue to Chronic nephritis

Due to \_\_\_\_\_

Other conditions Colloid goiter

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

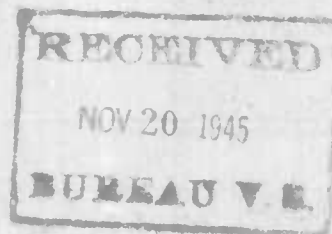
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M. V. Palmer M. D. or other \_\_\_\_\_Address Easton, Maryland Date signed 11/13/45



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-c

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

### 1. PLACE OF DEATH

County Talbot County

City or town Coston, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

M. Memorial Hospital

How long in hospital or institution? 12 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Coston, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Thomas Wilson

### 3. (b) Social Security Number

220-12-0921

4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced married

B. (b) Name of husband or wife Mrs. Mildred Wilson

B. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 20, 1898

8. AGE: Years 57 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual occupation General Office work

11. Industry or business

12. Name Jessie P. Wilson

13. Birthplace Md.

14. Maiden name Constance Stoddard

15. Birthplace Md.

16. Informant Mrs. Mildred Wilson

Address Coston, Md.

17. Burial Date thereof 11/26/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Coston, Md.

18. Funeral director W. H. Perkins

Address Coston, Md.

19. 11/25 19 45 N. H. Merino  
(Date reg'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 19 45 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 19 45 to November 23 19 45 and that I last saw him alive on November 23 19 45

Immediate cause of death Bronchogenic carcinoma

DURATION

1 year?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Diabetes mellitus 6 months

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M. V. Palmer 12/7  
M. D. or other \_\_\_\_\_

Address Coston, Maryland Date signed 12-7-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11379

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DEC 6 1945

BUREAU V.S.